STATISTICAL BULLETIN

METROPOLITAN LIFE INSURANCE COMPANY

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Safeguarding the Health of American Troops Abroad

THE global war in which we are engaged and the increasing tempo of our participation have created a huge task for those responsible for the health of our men. The splendid health record of troops stationed at home is well known to the American public. Strenuous efforts are likewise being made to safeguard the health of our men abroad. The difficulties of the task may be realized from the fact that American soldiers, sailors, and marines are now stationed all the way from the frozen Arctic to the steaming tropical jungles. Our men are not only exposed to every conceivable climate, but to many diseases which are rare or totally absent from this country. Faced with this complex problem, our military authorities are doing their utmost to keep the men fit, even though it means drawing into service a large proportion of our physicians.

The northern regions—Alaska, Greenland, and Iceland—in which our forces are located, present no problems with which we, in this country, are not already familiar, except as they may be somewhat intensified. As regards disease, the greatest menace is from respiratory conditions; but suitable protection of the body with warm clothing, abundant food, and other measures suffice to control them under ordinary conditions. The health record of our troops in these regions has been good, and may be expected to remain so. Apart from disease, the greatest danger is from freezing as a result of prolonged exposure.

A goodly number of our troops are located in Great Britain and other places in the temperate zone where health conditions are similar to those under which most Americans live, and where medical and public health organization is as well developed as our own. Available reports show that the health of our men in such regions has been maintained at an extraordinarily high level.

In contrast, the tropical and subtropical regions present a host of new problems to our military physicians. The tropical regions in which our troops are now located girdle the globe — the Caribbean Islands, Brazil, West Africa, North Africa, Egypt, Mesopotamia, India,

and the many island groups in the South Pacific. The diseases present in this huge area are largely insect-borne and include malaria, typhus, dysentery, yellow fever, plague, and cholera, as well as others of which even the names are unknown to most Americans, such as kala-azar, dengue fever, and sandfly fever. Some of these diseases, like malaria, are common to practically all of these regions, whereas others, like yellow fever, are fairly localized. Everywhere, however, the heat itself gives rise to serious medical problems, because of its direct effect on the troops or because of the difficulties it brings in protecting their food and water supplies. These are particularly acute during active fighting and in near-by occupied areas.

It is no easy task to organize a large wartime medical service and to train the specialized personnel required to combat these tropical diseases. It will be instructive to review a few important medical problems and to see how they are being met. In order to judge what can be accomplished, reliance must be placed largely upon peacetime data, because few statistics are available for the current war. Such data indicate that even in the worst tropical areas, troops who are under competent medical and sanitary supervision have a record of health and efficiency far superior to that of native populations.

All our troops are protected against typhoid and smallpox, and those who are at all likely to be exposed to yellow fever, typhus, and cholera are inoculated against these diseases. Against many others, reliance must be placed on sanitary measures directed to the destruction of the disease-transmitting insects or to reducing exposure to them by screening of buildings, by protective clothing and netting, and by use of repellent substances. Such measures are the main defense against sandfly fever and dengue, which are major causes of sickness in some areas but fortunately are seldom fatal.

Malaria is by far the most serious disease problem. This is the outstanding killer in many tropical countries. Its control is difficult, because we have no specific method of prophylaxis. Under normal conditions control depends chiefly upon destroying the breeding places of the malaria-carrying mosquitoes. These mosquitoes, however, are so prevalent that it is impossible to prevent infection, but its ravages can be checked by routine administration of quinine or synthetic drugs—principally atabrine. These do not prevent the disease, but merely postpone its manifestations. In combat areas, they are the only dependable measure. The Japanese conquest of the Dutch East Indies, the major source of the world's quinine, put a stop to our acquisition of further supplies of this drug. Fortunately, prior to that time we had built up a large stock and this, together with the greatly expanded production of atabrine, will meet our needs in even a protracted war.

No body of troops stationed in the

tropics can escape an appreciable amount of sickness from malaria. But intensive antimalarial procedures will reduce such disability to a minimum and prevent serious complications and deaths. Thus, in peacetime, malaria was a major cause of sickness among our troops stationed in Panama and the Philippines and among British troops stationed in the Orient and Africa. Fatal cases of the disease were, however, infrequent. The situation in India is of special interest. Normally, cases of the disease among natives are counted in the tens of millions, and deaths exceed a million each year. The current shortage of quinine has aggravated the situation there. Thus far, however, only relatively few cases have been reported among our American troops in India. In the South Pacific the malaria situation is less favorable, particularly in the combat areas like the Solomons. At Bataan it was a tremendous problem, and it was probably a factor in shortening our resistance there, although obviously not the decisive factor.

The intestinal disorders, including dysentery, likewise constitute an ever-present problem in the tropics. Troops located in those regions cannot escape them, especially where active military operations are going on, as in North Africa, the Solomons, and New Guinea. Even in peacetime these conditions were responsible for an appreciable part of the sickness toll among our troops in the Philippines. British troops in tropical regions likewise were affected. At Bataan our troops suffered about as much from these conditions as from malaria. Preventive control requires rigid adherence to prescribed sanitary procedures and instruction of the men in measures to protect themselves.

Typhus is popularly associated with eastern and southeastern Europe, but is by no means limited to these places. North Africa is an important focus of the disease; only this year severe epidemics have occurred in every part, from Morocco to Egypt. Typhus is of little danger to our troops fighting in Northern Africa. Relatively simple and tried sanitary procedures should probably suffice to keep them free from typhus in Africa as well as in other endemic areas. However, immunization has also been applied, although its effectiveness is still to be confirmed.

The climate itself is a specific hazard in the tropics, although the seasoned troops suffer far less from the heat than new arrivals. The incidence of illness due to exposure to heat has been relatively low in our peacetime armies located in the tropics, and this holds true for the British also. Relatively little disability has been reported among our troops in India.

It would be foolish to minimize the health problems that our troops are facing. Our military authorities are fully cognizant of them and are working at top speed to build up the facilities to meet them. Thus, our troops all over the world are being safeguarded to the greatest possible extent. The meager data available

indicate that our military physicians have already achieved much. Probably no body of fighting men in the tropics has ever had a health record anything like as good as that of our men stationed there. Sickness and death rates are appreciably lower than in the first World War, in the tropics as well as in other regions. However seriously the American public is inconvenienced by the withdrawal of physicians from civilian life, it is a small price to pay for protecting our men in service.

A Peak Year in American Marriages

AMERICAN marriages will reach a new high in 1942, with a total that will be near 1,800,000. This will mark the fourth year of successive increase in marriages in the United States and will be an increase of about 80 percent above the number for 1932, the low point of the depression period. The estimate for 1942 is derived from a comparison of the marriage licenses issued in the first 11 months of this year with the corresponding period of the year before, the records relating to 86 cities of 100,000 or more inhabitants. The essential results are shown in the table on page 6. According to the census of 1940, these cities included one third of our total population. In arriving at the estimate, some allowance was made for the fact that the increase in marriages may have been slower in the communities and rural areas outside of these cities.

For the reporting cities as a whole, the increase in marriage licenses issued this year over last was just over 10 percent. Generally speaking, the greatest gains were made in the large cities of the Far Western and Southern areas, while those in the Northeastern area, taken as a whole, have actually fallen behind in 1942 compared with 1941. For example, the cities in the Mountain and Pacific Coast States, as a group, have gained by 52 percent. In this area San Diego made the record gain of 176 percent, and Tacoma came next with an increase of 106 percent. San Francisco went ahead by 76 percent and Los Angeles by 35 percent. The sizable increases in marriages in the cities of the Western States undoubtedly reflect the prosperity being enjoyed as a result of the rapid development of defense industries which have attracted large numbers from rural areas and from other cities. The presence of great naval and military training stations around San Diego is also a factor in that city's striking increase in marriages.

Cities reporting from the South Atlantic States and from the South Central States experienced an increase of 33 percent in marriages last year. Florida cities rank particularly high, Tampa showing a gain of almost 80 percent, Jacksonville of 70 percent, and Miami of 50 percent. The increase for San Antonio amounted to 73 percent. The very appreciable gains for the

cities in the Southern States may be attributed, in some degree, to the concentration of men in training for the military and naval services in this area of the country. Marriage licenses issued in Washington, D. C., were 46 percent greater than a year ago. Baltimore, now a large center for shipbuilding and the manufacture of airplanes, went ahead in marriages by 25 percent.

In the West North Central area the large cities for which data were collected showed a net gain of more than 13 percent in marriage licenses issued from 1941 to 1942. Wichita ranked first, with an increase of 39 percent. On the other hand, Duluth fell behind by 15 percent and Des Moines by 27 percent. It is to be noted, in this connection, that Duluth lost in population since the census of 1940, while Des Moines remained practically stationary.

Of the cities of 100,000 or more reporting from the East North Central States, only three—Detroit, Fort Wayne, and South Bend—issued more marriage licenses in 1942 than in 1941. Chicago, the second largest city in the country, issued 4.8 percent fewer marriage licenses during the first 11 months of 1942 than the like period of 1941.

A rather mixed picture is presented by the cities in the Middle Atlantic States from which data were gathered. Albany made the best showing, with a gain of 16 percent. In New York State, Buffalo, Rochester, Syracuse, Utica, and Yonkers fell behind their status of a year ago. The record for New York City was 6.3 percent below the previous year, while Philadelphia, the second largest city of this area, forged ahead by 8.4 percent. Many of the cities in this area which recorded decreases in marriage licenses issued, lost in population since the census of 1940. However, Philadelphia, which lost in population in the decade from 1930 to 1940, gained in numbers in the last two years.

The New England States also present no definite pattern, although the cities of this area, taken as a whole, had 3.5 percent fewer licenses issued this year than last. On the one hand Hartford gained by 20 percent and Bridgeport by almost 17 percent, while Boston's record was the poorer in 1942 by 2.2 percent. The differences noted in the cities of the New England and Middle Atlantic States, as well as in the East North Central States, may, in part, reflect the unevenness of the development of war industries in this section of the country. It is also likely that many of the cities which had their war industries well developed before this year, had already experienced their boom in the marriage rate in 1941.

A comparison of the month-by-month record of licenses issued by the reporting cities shows that, for the group as a whole, the increases for this year were concentrated in the periods from January through April and from September through November. The gain for the first four months of 1942, compared with the same period of 1941, amounted

to about 32 percent; May through August decreased by 4 percent, while September through November increased by 11 percent.

One effect of the record number of marriages in 1942 will be to keep the number of births for 1943 at about the high level it has now reached. However, the outlook is that marriages in 1943 may not reach the record for 1942. The momentum given to the marriage rate by the upswing in business will probably have spent itself, and the opportunity for marriages will decrease as more men go overseas.

PERCENT OF CHANGE, FROM 1941 TO 1942, IN MARRIAGE LICENSES ISSUED IN AMERICAN CITIES OF 100,000 OR MORE INHABITANTS (JANUARY THROUGH NOVEMBER OF EACH YEAR)

City	Percent Increase (+) or Decrease (—)	City	Percent Increase (+) or Decrease (—)	City	Percent Increase (+) or Decrease (—)
All cities	**+ 10.1**	**East North Central**	**— 5.2**	Richmond, Va.	+ 24.3
New England	**— 3.5**	Akron, Ohio*	— 6.9	Charlotte, N. C.*	+ 36.2
Boston, Mass.	— 2.2	Canton, Ohio*	— 20.2	Atlanta, Ga.*	+ 27.7
Cambridge, Mass.	— 5.8	Cincinnati, Ohio	¶	Jacksonville, Fla.*	+ 70.0
Fall River, Mass.	— 22.0	Cleveland, Ohio*	— .3	Miami, Fla.*	+ 50.3
Lowell, Mass.	— 26.0	Columbus, Ohio*	— .5	Tampa, Fla.*	+ 78.6
New Bedford, Mass.	— 12.2	Dayton, Ohio*	— 6.0		
Somerville, Mass.	+ 1.9	Toledo, Ohio*	— 32.2	**East South Central**	**+ 6.7**
Springfield, Mass.	— 9.5	Youngstown, Ohio*	— 27.4	Louisville, Ky.*	+ 36.2
Worcester, Mass.	— 12.5	Fort Wayne, Ind.*	+ 3.3	Chattanooga, Tenn.*	— 31.0
Providence, R. I.*§	— 3.2	Gary, Ind.*	— 4.4	Knoxville, Tenn.*	— 19.5
Bridgeport, Conn.	+ 16.7	Indianapolis, Ind.	¶	Memphis, Tenn.*	— 52.1
Hartford, Conn.‡	+ 19.7	South Bend, Ind.*	+ 9.5	Nashville, Tenn.	¶
New Haven, Conn.	+ 1.0	Chicago, Ill.*	— 4.8	Birmingham, Ala.*	+ 14.7
		Peoria, Ill.*	— 17.2		
Middle Atlantic	**— 2.6**	Detroit, Mich.*	+ 5.8	**West South Central**	**+ 40.7**
Albany, N. Y.	+ 16.0	Flint, Mich.*	— 1.8	New Orleans, La.	+ 42.3
Buffalo, N. Y.	— 11.9	Grand Rapids, Mich.*	— 10.3	Oklahoma City, Okla.*	+ 51.1
New York, N. Y.	— 6.3	Milwaukee, Wis.‡	— 13.3	Tulsa, Okla.*	+ 32.3
Rochester, N. Y.	— 7.7			Dallas, Tex.*	+ 22.6
Syracuse, N. Y.	— 8.2	**West North Central**	**+ 13.2**	Fort Worth, Tex.*	+ 26.7
Utica, N. Y.	— 2.6	Duluth, Minn.*	— 14.7	Houston, Tex.*	+ 31.8
Yonkers, N. Y.	— 2.6	Minneapolis, Minn.*	+ 8.6	San Antonio, Tex.*	+ 72.5
Camden, N. J.	+ 7.3	St. Paul, Minn.*	+ 6.4		
Elizabeth, N. J.‡	— .9	Des Moines, Iowa*	— 27.1	**Mountain and Pacific**	**+ 51.7**
Jersey City, N. J.*§	+ 12.1	Kansas City, Mo.*	+ 31.6	Denver, Colo.	+ 35.0
Newark, N. J.	+ 8.6	St. Louis, Mo.	¶	Salt Lake City, Utah*	+ 4.2
Paterson, N. J.	— .7	Omaha, Nebr.*	+ 17.1	Seattle, Wash.*	+ 66.7
Trenton, N. J.	+ 8.3	Kansas City, Kans.*	+ 19.4	Spokane, Wash.*	+ 5.0
Erie, Pa.*	+ 3.6	Wichita, Kans.*	+ 39.3	Tacoma, Wash.*	+105.8
Philadelphia, Pa.	+ 8.4			Portland, Oreg.*	+ 18.4
Pittsburgh, Pa.*	— 3.1	**South Atlantic**	**+ 35.7**	Los Angeles, Calif.*†	+ 35.1
Reading, Pa.*	— .1	Wilmington, Del.*	+ 13.7	Oakland, Calif.*	+ 51.6
Scranton, Pa.	¶	Baltimore, Md.	+ 25.0	Sacramento, Calif.*	+ 84.9
		Washington, D. C.	+ 46.3	San Diego, Calif.*	+176.1
		Norfolk, Va.	¶	San Francisco, Calif.	+ 75.9

*The percent change in this case relates to the county in which the city is located.
§ January to October. ‡The percent of change is based on the marriages performed.
†Includes the city of Long Beach. ¶The report had not been received at the time of going to press.

No Shortage of Babies During Our First Year of War

ONE of the big events on the home front during our first year of war was a bumper crop of new babies. At least 2,800,000 were born in the United States during 1942, according to preliminary reports received so far. This is an all-time maximum of births in the United States; the previous highest point, 2,600,000, was reached in 1921—in the period after the close of the first World War. The present birth rate of about 21 per 1,000 has not been equalled in 15 years; even so, it is still materially less than the rate reported at the time of the first World War—namely, about 25 per 1,000—and it is only the growth of the total population which, combined with the present birth rate, has resulted in a total number of births greater than, say, 25 years ago.

But while the birth rate is not as high as in 1917, the lives of babies and mothers in America are far safer now than they were 25 years ago. Out of 1,000 babies born alive in 1917, approximately 95 failed to survive to their first birthday. Today deaths in the first year of life number about 45 per 1,000 live births, a decrease of more than 50 percent. The maternal mortality rate has decreased similarly during the interim. In 1917 deaths of mothers from diseases and conditions associated with pregnancy and childbirth numbered 6.6 per 1,000 live births. Today the rate is about 3 per 1,000 live births, a decrease of more than 50 percent from the earlier figure. The trends of the rates for births, infant deaths, and maternal deaths in the United States since 1915, as reported by the Bureau of the Census, are shown on page 8.

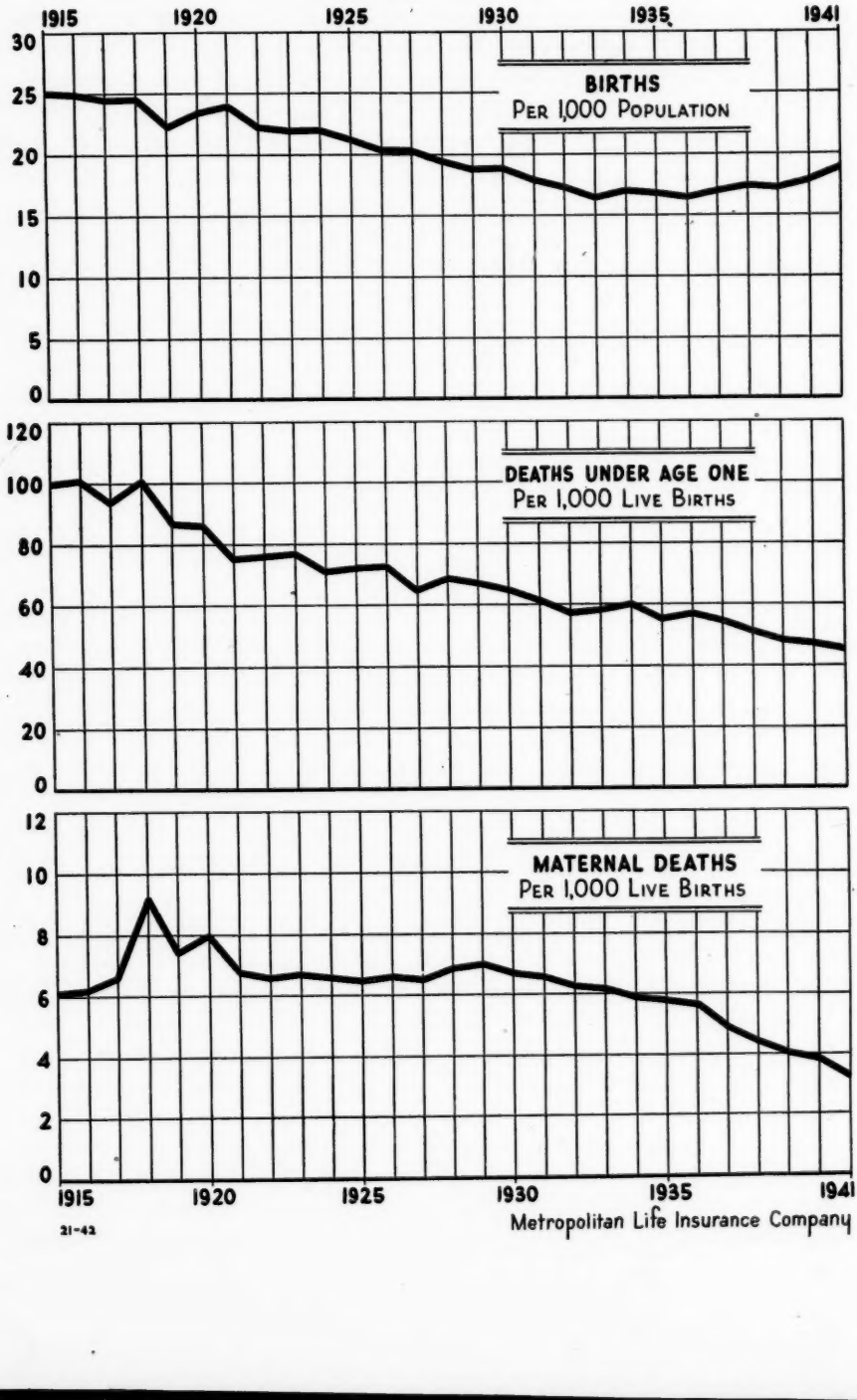
The first curve on the chart relates to the birth rates. From 1915 the birth-rate curve moved downward, touching the lowest point, 16.6, in 1933. Beginning with 1934 the trend of the birth rate was reversed, and the curve continued to rise generally, so that by 1941 births numbered 18.9 per 1,000 population. In 1942, not shown on the chart, the birth rate may exceed 21.

The second curve on the chart shows the trend of the infant death rate—that is, the number of deaths of infants under 1 year of age per 1,000 live births. Starting at 100 in 1915, the mortality has declined fairly regularly, and by 1941 was down to 45. The rate for 1942 will be still less, according to provisional reports received to date.

The third curve on the chart relates to maternal mortality—that is, the annual number of deaths of mothers from diseases and conditions associated with pregnancy and childbirth per 1,000 live births. This curve is characterized by a practically stationary level in the neighborhood of 6.5 per 1,000 from 1915 to 1931, except for the pandemic influenza period around 1918 to 1920, when the mortality was quite

BIRTHS, INFANT MORTALITY, AND MATERNAL MORTALITY

United States Birth Registration States, 1915 to 1941



high. In 1932 the death rate of mothers decreased to 6.3 per 1,000. Thereafter the rate fell regularly, so that in 1941 the maternal death rate was 3.2 per 1,000. In 1942 the rate has been reduced still further.

Since the future number of our children is determined mainly by birth rates and infant death rates and is also influenced by maternal death rates, the public health efforts associated with these items are of great significance. Our population of children under age 15 has decreased by 3,000,000 in 10 years. It was at its maximum in 1930 when the Census enumerated 36,100,000 of such children; in 1940 the number was only 33,100,000. The decline of infant mortality, although phenomenal has not by itself been sufficient to overcome the deficit created by the comparatively low birth rates prevailing in recent years. In order that our child population under age 15 in the year 1950 shall equal at least the number enumerated at the 1940 Census, our annual births for the next seven years must average about 2,250,000. Since this figure is less than the number of births in 1942 by as many as half a million, and since the infant mortality and maternal mortality may be expected to decline still further, it is very possible that this goal for 1950 will not only be reached but measurably exceeded.

Accidental Deaths During 1942

ACCIDENTS took fewer lives during 1942 than in the preceding year, although a substantial increase might have been expected in view of the marked rise in the fatal-accident rate that took place in the initial year of our participation in the first World War. In 1917 the rate rose to a point which had not again been equalled down through 1941, and apparently was not equalled in 1942. From the incomplete information now available, only a rough approximation can be made, but it seems probable that the fatal-accident toll in 1942 may be fewer by 8,000 or more than the 101,500 lives taken in 1941.

A more detailed review of the data tempers any belief that a sudden improvement has taken place in the safety habits of the American people. The decline in 1942 over 1941 was due entirely to a reduction in motor vehicle fatalities—brought about mainly, if not wholly, by travel restrictions. Motor vehicle deaths may be down 12,000 or even more for the year. Each of the other major causes of accidental deaths—home, public other than motor vehicle, and occupational accidents—apparently increased during 1942. There was also a considerable number of accidental deaths among military personnel in the United States.

That our efforts over a long period of years to promote safer living in the United States have nevertheless been fruitful, and have served us well in the present great emergency, is clearly brought out by a compar-

ison of the record for 1942 with that for 1917, when the automobile had not become the great accident problem it is today. If the accident rate this year had been as high as it was in 1917 in the Registration Area of the United States, there would have been 118,000 deaths from accidents of all kinds instead of about 93,000.

Catastrophes—those in which the toll is at least five lives—were more frequent and took many more lives in 1942 than in 1941. Up to the closing weeks of 1942 the number of deaths in catastrophes totalled around 2,600, more than 2½ times as many deaths as in 1941 catastrophes. In 1941 the largest single accident accounted for 37 lives. Most tragic this year was the night club fire in Boston, in which 488 were killed. Two coal mine explosions, one in West Virginia and the other in Colorado, took 56 and 34 lives, respectively. There were 54 victims in an explosion at an ordnance plant in Illinois. Close to 50 persons died when sodium fluoride, mistaken for powdered milk, was used in the preparation of food at a mental disease hospital in Oregon. A double disaster—the sinking of a tanker and a barge on Lake Erie—took 32 lives. The premature explosion of tons of gelatinite at a quarry in Pennsylvania killed 31 men.

Nature also contributed many deaths to the toll, tornadoes claiming more lives in 1942 than in any of the preceding five years. Most disastrous were the tornadoes which took a toll of 111 lives in seven Southern and Midwestern States in March. Three series of tornadoes killed more than 100 persons in Oklahoma during the months of April to June.

It is interesting to note that there were many serious catastrophes in 1917 also. An explosion in a Pennsylvania munitions plant in April 1917 took 112 lives. A copper mine fire in Montana and coal mine explosions in Colorado and Kentucky took 163, 121, and 62 lives, respectively. There were a series of tornadoes toward the end of May of that year which killed 300 persons.

No one will dispute the fact that we lose far too many valuable lives unnecessarily in accidents every year. It is discouraging to observe that at least as many persons died from injuries sustained in accidents every month in 1942 in the United States as there were civilians mortally wounded by enemy air raids on Great Britain in any one month of the war so far. As a matter of fact, in several months our accident toll exceeded by 1,000 deaths or more the 6,955 British air-raid fatalities suffered in September 1940, when they were at a peak figure.

Comparative Data on the Causes of Death Among Industrial Policyholders

The following table shows the mortality among Industrial policyholders for November 1942 and November 1941, together with the death rates for the first 11 months of 1942, 1941, and 1940.

DEATH RATES* PER 100,000 POLICYHOLDERS FROM SELECTED CAUSES. WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS — METROPOLITAN LIFE INSURANCE COMPANY

CAUSES OF DEATH	ANNUAL RATE PER 100,000 POLICYHOLDERS*				
	November 1942	November 1941	Year to Date: End of November		
			1942	1941	1940
ALL CAUSES—TOTAL	731.1	665.4	736.7	743.2	757.9
Typhoid fever	0.4	0.3	0.4	0.5	0.7
Measles	.2	.2	.5	.9	.3
Scarlet fever	.3	.4	.4	.4	.6
Whooping cough	.8	.9	1.0	1.3	1.2
Diphtheria	1.2	.8	.6	.7	.8
Influenza	4.0	3.0	4.1	7.9	7.5
Pneumonia (all forms)	27.3	23.3	28.7	31.0	35.5
Tuberculosis (all forms)	36.7	35.9	41.8	42.5	44.1
Tuberculosis of respiratory system	33.2	32.4	37.6	38.6	39.7
Syphilis	10.0	9.0	10.7	11.1	11.4
Cancer (all forms)	106.1	94.7	105.3	102.3	101.1
Diabetes mellitus	26.7	24.1	27.8	27.0	28.8
Cerebral hemorrhage	60.4	56.3	60.4	59.9	60.3
Diseases of the coronary arteries and angina pectoris	54.8	51.6	57.2	53.4	51.3
Other chronic heart diseases†	154.6	132.1	156.0	153.1	156.5
Diarrhea and enteritis	4.7	5.3	4.5	4.8	4.6
Appendicitis	4.7	5.6	5.8	7.3	8.9
Chronic nephritis	45.3	43.9	49.5	50.7	55.6
Puerperal state—total	3.7	3.6	4.4	4.6	4.7
Suicides	7.0	5.1	7.2	7.1	8.2
Homicides	3.5	3.0	3.7	3.6	3.7
Accidents—total	45.2	45.4	50.5	50.3	46.5
Home accidents	9.9	9.1	11.4	10.7	11.4
Motor vehicle accidents	13.7	20.8	16.9	20.5	17.5
War deaths	5.7	—	4.3	.1	.2
All other causes of death	127.9	121.0	111.9	123.0	125.3

*The rates for 1942 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†International List (1940) titles 92, 93 (c), (d), (e), and 95.

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STATISTICAL BULLETIN
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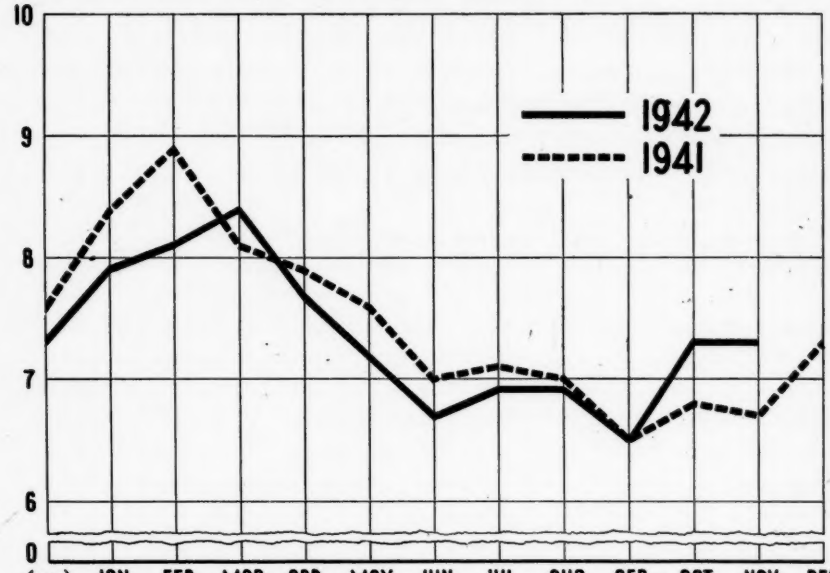
MORTALITY FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE COMPANY
INDUSTRIAL DEPARTMENT, WEEKLY PREMIUM-PAYING BUSINESS

DEATH RATES PER 1,000 ANNUAL BASIS (*1942 figures are provisional*)



(DEC.)	JAN.	FEB.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.
1941	8.3	8.8	8.1	7.9	7.6	7.0	7.1	7.0	6.5	6.8	6.7	7.3
1942	7.9	8.1	8.4	7.7	7.2	6.7	6.9	6.9	6.5	7.3	7.3	

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